This form may be completed online, printed and mailed to the address listed below.

ATTACHMENT A

STATE OF NEBRASKA
Department of Health and Human Services
Regulation and Licensure
Credentialing Division
P.O. Box 94986,
Lincoln, Nebraska 68509-4986 ** 402-471-2117

MEDICAL NUTRITION THERAPY APPLICATION FOR A LICENSE

Please Type or Print Clearly – It is your responsibility to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

SECTION A – DEMOGRAPHIC INFORMATION (All applicants must complete this section) The information contained in this section (except phone # and SS#) *are public information and will appear on the internet* www.hhs.state.ne.us/lis/lisindex.htm				
1	Applicant	First:	Middle:	Last:
2	Public Address	Street/PO/Route:		
		City:	State:	Zip:
3	Telephone	# during normal business hours:		
4	Social Security Number: (this is NOT public information and will not be on the Internet) It is required for child support enforcement purposes; and for potential disclosure of reportable actions to the Federal department of Health and Human Service's Healthcare Integrity and Protection Data Bank (HIPDB)			
5	Place of Birth:	City/State/Country:		
6	Date of Birth:	Month/Day/Year:		
	(To verify your date of birth, submit a certified/notarized copy of your birth or marriage certificate, driver's license, college transcript, or similar documentation)			

SECTION B – LICENSURE APPLICATION CATEGORY (All applicants must check the appropriate application method)

Initial Licensure:

☐ **Option 1:** Application based on being a Registered Dietitian with the American Dietetic Association (ADA). You must submit official documentation of being a Registered Dietitian with the ADA or an equivalent entity.

Registration Number:		Date Issued:	
If not ADA name of equivalent entity:			

☐ **Option 2:** Application based on a baccalaureate degree from an accredited college or university with a major course of study in human nutrition, food and nutrition, dietetics, or an equivalent major course of study AND Completion of a program of at least 900 supervised clinical experience (Attachment A1 must be completed as verification);

☐ **Option 3:**

☐ Application based on a master's or doctoral degree from an accredited college or university in human nutrition, nutrition education, food and nutrition, or public health nutrition or in an equivalent major course of study.

OR

☐ Application based on a master's or doctoral degree from an accredited college or university which includes a major course of study in clinical nutrition with not less than a combined 200 hours of biochemistry and physiology and not less than 75 hours in human nutrition (Section D must be completed as verification).

Reciprocity:

☐ Application based on holding a license/certification in another jurisdiction for at least one full year, and practicing under such license/certification in the other jurisdiction for at least one of the three years immediately preceding applying for licensure in Nebraska.

APPLICATION FEE: Determine the month and year in which you are submitting your application according to the following chart.

YEAR	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Even	32	32	32	32	32	32	32	32	31	31	31	31
Odd	31	31	26	26	26	26	26	26	32	32	32	32

Make fee payable to "Credentialing Division" ***NOTE: All licenses expire September 1st of odd-numbered years.***

SECTION C – CONVICTION / LICENSURE INFORMATION: All applicants must complete this section .				
1	Have you ever been convicted of a misdemeanor or a felony (does not include traffic violations)? **Answer Yes or No**			
	If yes, state what crime, date of conviction, name, location of court (City, County, State)			
2	Are you licensed or certified in another state? **Answer Yes or No**			
	If yes, indicate category of licensure:		State(s) of Licensure:	
3	Has Disciplinary Action been taken on your license/certificate? **Answer Yes or No**			
	If yes, state date and type of action:			
	Name and address of entity taking such action:			
4	Have you ever surrendered your license/certification? **Answer Yes or No**			
	If yes, state date and type of surrender; state(s) of such surrender:			
5	Have you ever been denied licensure/certification or refused renewal (other than non-payment of renewal fees) **Answer Yes or No**			
	If yes, state date and type of action; Name and address of entity taking such action:			

If you answered YES to any of the questions above, you must request the following documents be sent directly to this office:

- Official Court Record, which includes charges and disposition
- Copies of Arrest Records
- A letter from the applicant explaining the nature of the conviction
- All addiction/mental health evaluations and proof of treatment (if the conviction involved a drug and/or alcohol)
- If currently on probation, a letter from your probation officer referencing your probationary progress or date of release
- Official Documents from the State Board in which the disciplinary action was taken

ONLY COMPLETE THIS SECTION IF YOU APPLIED UNDER OPTION 4
SECTION D - EXPERIENCE (If you are applying for licensure based on a master's or doctoral degree which included a major course of study in clinical nutrition, you must complete the appropriate section below IF YOU ARE APPLYING BY OPTION 4).

MASTER'S OR DOCTORAL DEGREE I have completed a master's or doctoral degree which included a major course of study in clinical nutrition and consisted of not less than a combined 200 hours of biochemistry and physiology and not less than 75 hours in human nutrition. List qualifying courses, number of academic hours earned for each course listed:

Name of Biochemistry and Physiology Courses	Hours	Name of Human Nutrition Courses	Hours

***Hours are calculated as:**
1 semester hour = 15 clock hours; 1 quarter hour = 10 clock hours; 1 trimester hour = 14 clock hours

SECTION E - EDUCATION (All applicants must complete this section, **EXCEPT THOSE APPLYING UNDER OPTION 1).**			
☐	Transcript attached		
☐	Transcript forwarded separately	Last name on the transcript:	

(If you are applying for licensure based on being a Registered Dietitian with the American Dietetic Association (ADA) you *do not* need to submit an official transcript)

INSTITUTION Name			
Address	Street/PO/Route		
	City	State	Zip
Month and Year degree granted:	Degree:	Major:	

SECTION F – ATTESTATION An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of $10 per day up to $1,000, or such other action as provided in the statutes and regulations governing the credential.

I hereby state that I am the person making application, I am of good moral character, and the statements on this application are true and complete.

I further state that:

☐ I have not practiced Medical Nutrition Therapy in Nebraska prior to this application for licensure; **or**

☐ I have practiced Medical Nutrition Therapy in Nebraska prior to this application for licensure (does not include internship time).

____ number of days in Nebraska prior to July 1, 2004

____ number of days in Nebraska after July 1, 2004

_____
(Signature of Applicant)

_____ date

All reciprocity applicants must complete Section G on page 4 of this application.

SECTION G - **RECIPROCITY; LICENSURE ISSUED ON THE BASIS OF A LICENSE OR CERTIFICATE IN ANOTHER JURISDICTION** (Complete this section if you hold a license or certificate to practice Medical Nutrition Therapy, in another jurisdiction and are applying for licensure by reciprocity. **(Attachment A4 must be completed by the State(s) in which your are licensed)**

1	Name of Agency Issuing License/Certificate:			
2	Address	Street/PO/Route:		
		City:	State:	Zip Code:
3	Date Issued:		License/Certificate No.	
4	Title of license/certificate			
	Name of Written Examination:			

5	Have you been in the active and continuous practice of Medical Nutrition Therapy under such license or in an accepted residency or graduate program for one year of the three years immediately preceding the date of an application for Nebraska license? **Answer Yes or No**		
	5a	If in an accepted residency or graduate program, provide the name of the facility or graduate program, address, and dates actively engaged in the practice of Medical Nutrition Therapy. (Use an additional sheet if space is inadequate.)	

Facility	Address	Dates

	5b	Give location, address, and dates actively engaged in the practice of medical nutrition therapy. (Use an additional sheet if space is inadequate.)	

Facility	Address	Dates

6	Have you been in active and continuous practice of medical nutrition therapy under license by examination in the state, territory, or District of Columbia from which you come for at least one year following the issuance of such license? **Answer Yes or No**		
	6a	Give location, address, and dates actively engaged in the practice of Medical Nutrition Therapy. (Use and additional sheet if space is inadequate.)	

7	Have you requested to have the certification (Attachment A2) of your medical nutrition therapy license sent to Nebraska? **Answer Yes or No**		

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE - Credentialing Division
P.O. Box 94986, Lincoln, Nebraska 68509-4986
402-471-2117

AFFIDAVIT OF SUPERVISED EXPERIENCE

(Print or Type)

I, _____, state that I am a
(supervisor's name)

qualified supervisor licensed in the profession of Medical Nutrition Therapy, License # _____ and

that I am acquainted with _____, and he/she
(applicant's name)

has completed not less than 900 hours of a planned continuous clinical experience in human nutrition,

food and nutrition, or dietetics under my supervision.

_____ _____
Date (Print/type) SUPERVISOR Name Title

_____ _____
License number of Supervisor Agency/Institution

_____
Street Address

_____
City State Zip

_____
Supervisor's *Signature*

FORWARD THIS COMPLETED FORM TO: NEBRASKA Department of Health and Human Services
Regulation & Licensure
Credentialing Division
Medical Nutrition Therapy
P. O. Box 94986
LINCOLN, NE 68509-4986
(402) 471-2117

YOU MAY MAKE ADDITIONAL COPIES OF THIS FORM IF SUPERVISED BY MORE THAN ONE SUPERVISOR

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE - Credentialing Division
P.O. Box 94986, Lincoln, Nebraska 68509-4986
402-471-2117

CERTIFICATION OF MEDICAL NUTRITION THERAPIST LICENSURE

(Must be completed by certifying/licensing agency)

(Print or Type)

Our records indicate that _____ was
(Applicant's Name) (profession)

licensed/certified as a _____and was issued license/certificate number _____, on _____, _____, and

expires on_____, _____. The license or certificate was issued on the basis of

a written examination_____ _____
(Name of Examination) (Date of Administration of Examination)

_____
(National Mean)

The passing score requirement for this examination was _____.
The applicant's score was _____.
(If a written examination was not required, attach copies of the documentation required for a license or certificate issued by your state.)

Requirements for licensure or certification in _____ at the time this license or certificate was issued were:
(Issuing State)

_____
and are currently: _____
(Copies of regulations/requirements for licensure or certification at the time of issuance and present requirements may be attached as documentation.)

It is further verified that based on the records in this department the applicant's license has been:

(a) suspended ❑ Yes ❑ No;
(b) revoked ❑ Yes ❑ No;
(c) had other disciplinary action ❑ Yes ❑ No;

If yes to any of the above, please explain: _____

_____

(d) has been maintained in good standing up to and including the present date ❑ yes ❑ no

So far as the record of this agency is concerned, the applicant is entitled to the endorsement of this agency.

Date: _____

_____
Signature (No Stamp)

_____
Name and Title

OPTIONAL:
Telephone Number: _____

_____
Licensing Agency

_____
Address

(S E A L)

_____
City/State/Zip Code